No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21163

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 620

1. PLACE OF DEATH
(a) County BUCHANAN
(b) City or town ST. JOSEPH (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 36 yrs 10 days (Specify whether years, months or days) In this community [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME WILLIAM V. PETRIE
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex MO
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE — Years: Est. 80 ? — Months: ? — Days: ? — If less than one day ____ hr. ____ min.
9. Birthplace ? Michigan (City, town, or county) (State or foreign country)
10. Usual occupation Bookkeeper
11. Industry or business
MOTHER
12. Name Charles Petrie
13. Birthplace ? Canada Fr (City, town, or county) (State or foreign country)
FATHER
14. Maiden name Mary A. Crawford
15. Birthplace ? Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Charles H. Petrie
(b) Address 920 N. 22nd Ste. St Joseph
17. (a) Mt Olivet (Burial, cremation or removal) (b) Date thereof 6-18-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director Heaton Bittle & Bowman Funeral Home
(b) Address 519 So 10th St Joseph Mo.
19. (a) June 17 41 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1941 hour 4 minute 00 P.M.
21. I hereby certify that I attended the deceased from June 15 1941, 19__, to June 16, 19 41; that I last saw him alive on June 14, 19 41 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature George W Forman (M. D. or other) MD
Address State Hosp #2 St Joseph Date signed 6-15-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Jan W 16 -

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So. 10th St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.